S. No. 300
M—10-47
ev. 5-17-39
I 3906

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 9 1948 318
Registration District No.

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 30905
Primary Registration District No. 1003
Registrar's No. 8526

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G Phillips Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 months ?
(Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 2918 Delmar
21
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME: Ada Christian
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex: Female
5. Color or race: Col
6. (a) Single, widowed, married, divorced: Wid.
6. (b) Name of husband or wife: Not known
6. (c) Age of husband or wife if alive years
7. Birth date of deceased: JUne ? 1882 (Month) (Day) (Year)

8. AGE: Years Abt- 66 | Months 3 | Days ? | If less than one day hr. min.

9. Birthplace: Miss. (City, town, or county) (State or foreign country)
10. Usual occupation: Unknown
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: " (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: "
15. Birthplace: " (City, town, or county) (State or foreign country)

16. (a) Informant: Elizabeth Rhodes
(b) Address: 2601 N Whittier St
17. (a) Anatomical Board (Burial, cremation or removal) (b) Date thereof SEP 30 1948 (Month) (Day) (Year)
(c) Place: burial or cremation: Anatomical Board
18. (a) Signature of funeral director: Rowland Mortuary Service
(b) Address: 4104 Manchester Ave.
19. (a) SEP 30 1948 (Date received local registrar) (b) J. T. Medeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 15
year 1948 hour 8 minute 30 a M.
21. I hereby certify that I attended the deceased from Feb. 9, 1948 to Sept. 15, 1948
that I last saw her alive on Sept. 15, 1948
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Diabetes Acidosis;	
Cerebro Vascular Accident	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death): Ca. with Brain Metastases	
Major findings: Of operations	
Primary site Brain	
Of autopsy: None	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature: Herbert J. Christ, M.D. (or other)
Address: 2601 N Whittier Date signed 9/18/48

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.